Changes Under Consideration for the 2004 Uniform Benefit

Section Page	Description	Reason for Change
I.	Move the Schedule of Benefits to the beginning of the Guidelines. Clarify under Vision Services that non-routine eye exams are covered as medically necessary. Make other clarifications so that language is consistent with that in the remaining sections of Uniform Benefits. For example, clarifying cochlear implants on the schedule.	Relocation of the Schedule of Benefits will create uniformity between the Guidelines and the *It's Your Choice* book. The clarification for vision services results from a plan's misinterpretation that only one routine exam is covered.
II. Page 4-4	Clarify the definition of CONFINEMENT/CONFINED to read that it is one confinement if a participant is discharged or transferred to another facility for continued treatment of the same or related condition.	The current definition states it is one confinement if a participant is transferred to another facility for continued treatment of the same or related condition. A plan indicated that a participant is most likely to be discharged instead of transferred to another facility.
II. Page 4-5	Clarify the definition of DEPENDENT to indicate that they must be attending the institution they are enrolled in and that intersession courses are not included when determining full-time student status.	See memo, Guideline discussion item #4
II. Page 4-8	Define PRIOR AUTHORIZATION, which means obtaining approval from your plan before obtaining the services.	Prior authorization is referenced numerous times throughout the Uniform Benefits and has been the substance of numerous complaints and departmental determinations.
II. Page 4-8	Clarify the definition for REFERRAL to state that in most cases, it is the participant's responsibility to ensure a referral, when required, is approved by the plan before services are rendered.	Based on complaints and departmental determinations, it appears that participants are often unaware of their responsibility of ensuring their plan has approved a referral before services are rendered.
II. Page 4-9	Clarify the definition of USUAL AND CUSTOMARY CHARGE to state that plan approved referrals to non-plan providers are not subject to usual and customary charges. However, emergency services from a non-plan provider may be subject to usual and customary charges.	It has been identified that in some cases, plans are applying usual and customary charges to all services from non-plan providers. It is our view that plans have the opportunity to negotiate fees with non-plan providers when a referral is approved before services are rendered. In emergency situations, plans do not have this opportunity.
III., A., 2. Page 4-11 *and* III., C., 5. Page 4-21 *and* IV., A., 12., t., 3. Page 4-27	Add a statement that all non-urgent follow-up care must be received from a plan provider unless it is prior authorized by the plan.	This continues to be an issue when urgent or emergency care is sought from a non-plan provider, which usually results in denied claims.

Section Page	Description	Reason for Change
III., A., 9. Page 4-12	Clarify the coverage for ambulance service as that which covers licensed professional ambulance service to the nearest hospital where appropriate medical care is available when the conveyance is an emergency or urgent in nature and medical attention is required en route.	Clarification due to a complaint received.
III., A., 16. Page 4-14	Add coverage for the non-surgical removal of third molars when performed by an oral surgeon.	See memo, discussion item #1
III., A., 18. Page 4-15	Clarify coverage of retransplantation by identifying those transplants which are organ transplants, therefore benefits are excluded for retransplantation.	Clarification resulting from a departmental determination in which a plan denied a retransplantation of a tissue stating it was excluded from coverage.
III., C., 4. Page 4-20	Add clarification of coverage for cochlear implants, which include 80% coverage as determined medically necessary by the plan for the device, surgery for implantation of the device and follow-up sessions to train on use of the device. The hospital charges for the surgery are covered at 100%. The annual out-of-pocket maximum for durable medical equipment (DME) does not apply to this benefit.	Coverage for cochlear implants was added in 2003. Plans, participants and providers have requested clarification on the coverage.
IV., A., 5., a. Page 4-23	Clarify that under some circumstances, mandated temporomandibular joint (TMJ) benefits under Wis. Stat. §632.895 (11) may supercede the benefit for oral surgery/dental services.	Clarification resulting from complaints about the correction of malocclusion, which is covered if due to TMJ but otherwise is excluded.
IV., A., 10., d. Page 4-25	Clarify the exclusion to state that unit dose medication, which includes bubble pack or pre-packaged medications, except for medications that are unavailable in any other dose or packaging, is excluded.	Clarification due to questions and complaints received.
IV., A., 11., c. Page 4-25	Specifically list wigs and hair prostheses as an exclusion.	Requested by a plan.
IV., A., 12., c. & d. Page 4-25	Switch the order of c. and d. and list under the new d. that acts of domestic terrorism do not constitute military action.	Clarification due to more questions about coverage in the event of domestic terrorism acts.
IV., A., 12., ae. Page 4-28	Add exclusion denying any charges for, or in connection with, travel. This includes meals, lodging and transportation with exception of emergency ambulance transportation.	Clarification of existing practice.

Section Page	Description	Reason for Change
IV., B., 4. & 5. Page 4-28	Delete from both limitations ("Major Disaster or Epidemic" and "Circumstances Beyond the Plan's Control") the statement that neither the plan nor any plan provider shall have any liability or obligation. Add statement that in these cases, participants may receive covered services from non-plan providers.	See memo, discussion item #2
VI., D. Page 4-33	Revise the case management/alternate treatment language to be the same as the language used for the Standard Plans.	Reworded for clarity.
VI., L. Page 4-35	Clarify the proof of claim language to indicate that if claim is not submitted later than 12 months from the date the service was received, it should be submitted as soon as reasonably possible.	Reworded for clarity due to interpretation by a plan that claims should be submitted as soon as reasonably possible, but within 12 months from the date the service was rendered. Coordination of benefits can, on occasion, create delays that may extend beyond the 12 months. Medicare is one such example.
Throughout	Replace "e.g." with "for example" and "i.e." with "limited to."	Use of e.g. and i.e. has created some confusion for members in understanding their benefits.